Suicide Assessment and Intervention: Ethical Considerations and Practical Recommendations

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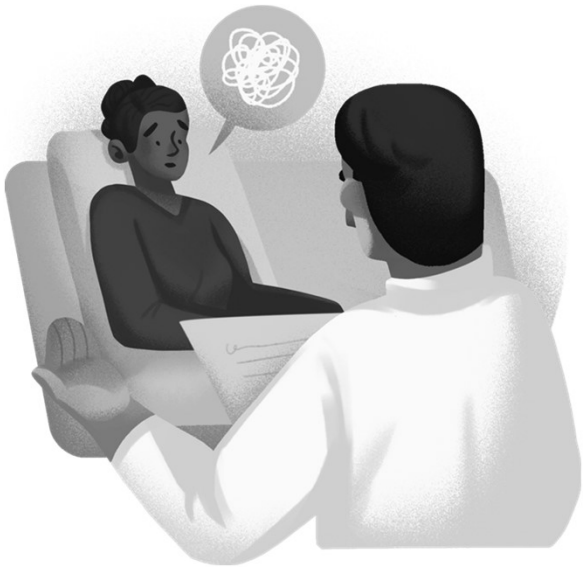

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Objectives

- Understanding Suicide
- Ethical Considerations in Suicide Assessment
- Suicide Assessment Process
- Suicide Intervention Strategies
- Self-Care for Counselors
- Questions and Discussion

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Understanding Suicide

- Suicide is the 11th leading cause of death in the US
- 48,183 Americans died by suicide in 2021
- There were an estimated 1.7M suicide attempts in 2021

Interpersonal theory of suicide
- Acquired capability
- perceived burdensomeness
- Failed belongingness

(CDC, 2022; Joiner et al., 2009)

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12.3 million

adults 18 and over had serious thoughts of suicide

1.7 million

adults 18 and over attempted suicide

3.3 million

youths ages 12-17 had serious thoughts of suicide

892 thousand

youths ages 12-17 attempted suicide

(SAMSHA, 2022)

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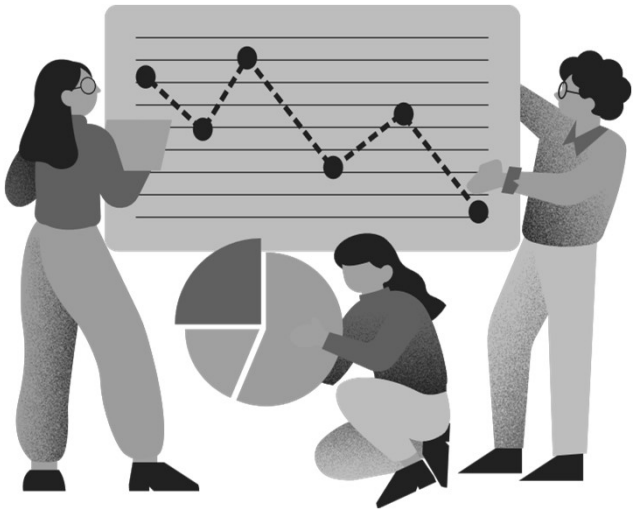
In 2020, suicide was the second leading cause of death for ages 1-44. The 11th leading cause of death in TN for all ages.

TN rankings by age for 2020:
#2 for ages 25-34
#3 for ages 10-24
#4 for ages 35-44
#6 for ages 45-54
#10 for ages 55-64



(CDC, 2022)

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Disparities in Suicide

- Suicide rates for ages 10-24 increased 52.3% between 2000-2021
- Suicide rates are highest for non-Hispanic American Indian or Alaska Native individual
- The rate of suicide attempts is five times higher for high school students who identify as lesbian, gay, or bisexual.*
- Veterans have an adjusted suicide rate that is 57.3% greater than non-veteran adults
- Adults with disabilities are three times more likely to report SI in past month.*

*limited data

(CDC, 2023)

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Why do counselors struggle with suicide assessment?

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Why do counselors struggle with suicide assessment?

- Emotional impact
- Fear of making the wrong recommendation
- Fear of liability
- Countertransference
- Lack of knowledge/skills to assess and treat suicidal clients
- Limited time and resources

(Jobes, 2017)

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Ethical Considerations in Suicide Assessment

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Ethical Codes

Exception to confidentiality with serious and foreseeable harm (Standard B.2.a)

Avoiding harm (Standard A.4.a)

Consultation (Standard B.2.a)

Collaborate with parents/guardians (Standard B.5.b)

Advocacy (Standard A.7.a)

State Laws

All available less drastic alternatives to hospitalization or treatment resource must be unsuitable to the person needed care

(ACA, 2014; Herlihy & Corey, 2015; Tenn. Code Ann. § 33-6-403)

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Substantial Likelihood of Serious Harm

- The person has threatened or attempted suicide or to inflict serious bodily harm on such person, or
- The person has threatened or attempted homicide or other violent behavior, or
- The person has placed others in reasonable fear of violent behavior and serious physical harm to them, or
- The person is unable to avoid severe impairment or injury from specific risks,

AND

- There is a substantial likelihood that such harm will occur unless the person is placed under involuntary treatment

(Tenn. Code Ann. § 33-6-501)

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Liability in Suicide Assessment

- Malpractice
  - Duty to provide reasonable care and falling short of that duty is seen as "causing" a client's suicide.
  - Wrongful death (by negligence)
  - Failure to diagnose, treat, admit, or respond
  - Misdiagnosis
  - Inadequate treatment, monitoring, and supervision (pg. 250)
  - Ignorance is not a defense
- Risk Management Approaches
  - Timely documentation
  - Collaboration
  - Consultation
  - Follow internal policies

**I am not an attorney or legal expert.

(Berg et al., 2009; Gutheil, 2004)

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Other Ethical Considerations

Carefully consider clinical interventions and the impact of the interventions (Wortzel et al., 2014; Johnson & Aldea, 2021).

Thoroughly document the rationale behind chosen intervention/ course of treatment (Johnson & Aldea, 2021)

Least restrictive environment - promotes the welfare and dignity of clients (Berg et al., 2009; Wang & Colucci, 2017).

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Other Ethical Considerations

Involuntary hospitalization has consequences. It may disrupt psychosocial roles and relationships and threaten protective factors that mitigate suicide risks on a long-term basis (Wortzel et al., 2014).

It may also increase the risk of suicide because of stigma, discrimination, impact on employability, trauma, isolation, and feeling of dehumanization. People who are detained, disconnected from their social circle, and experience trauma, abuse, and emotional distress are at high risk of suicide (Wang & Colucci, 2017).

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Human Rights Considerations

All persons with a mental illness shall:

- be treated with humanity and respect for the inherent dignity of the human person (Principle 1.2)
- have the right to protection from degrading treatment (Principle 1.3)
- be no discrimination on the grounds of mental illness (Principle 1.4)
- have the right to live and work in the community (Principle 3)
- be protected from harm including unjustified medication, abuse by other patients and staff, or other actions causing mental distress or physical discomfort (Principle 8.2)
- have the right to be treated in the least restrictive environment (Principle 9.1)
- be directed towards preserving and enhancing personal autonomy (Principle 9.4)

(Universal Declaration of Human Rights, 1948)

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Human Rights Considerations

- When a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission (Principle 15.1)
- A person may be involuntarily admitted to a mental health facility if, and only if, that person has a mental illness and considers:
  - there is a serious likelihood of immediate or imminent harm to that person or other persons; or
  - in the case of a person whose mental illness is severe and whose judgment is impaired, failure to admit is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative
  - Two independent qualified mental health providers must be in agreement on the need for involuntary admission

(Universal Declaration of Human Rights, 1948)

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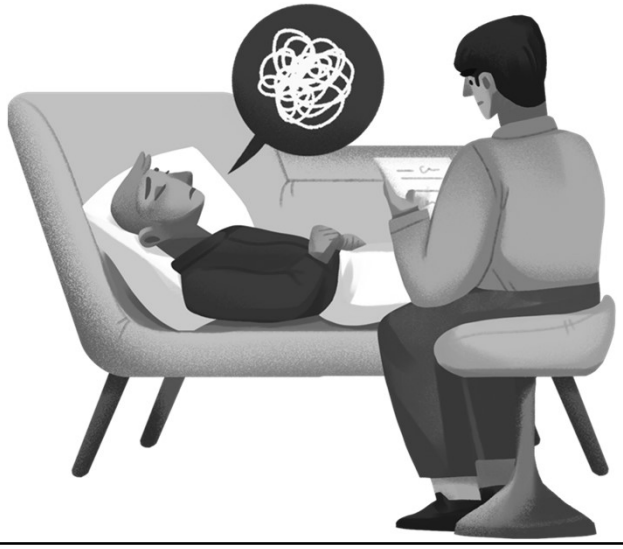
Comprehensive Suicide Assessment



- Formal assessment measures
- Client interview and collateral information
- Risk factors
- Warning signs
- Protective factors
- Risk assessment

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Formal Assessment Measures

Columbia-Suicide Severity Rating Scale (C-SSRS)

- Assesses the presence and severity of suicidal ideation and the level of risk
- Designed to differentiate suicidal ideation from suicide behavior (Gipson et al., 2016).
- Named the "gold standard" for assessing suicide by the FDA in 2012. However, it does not address the full range of suicidal ideation and behavior (Giddens et al., 2014)

Beck Scale for Suicidal Ideation (BSI)

- 19 items that measure the severity of actual suicidal wishes and plans (Beck et al., 1979)
- Commonly applied to clients who are already at risk of suicide (Andreotti et al., 2020)

*Researchers state that there is no single instrument considered to be the "gold standard" for suicide assessment (Andreotti et al., 2020).

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Client Interview

- Attend to your own anxiety and be mindful of how this may influence your interviewing style.
- Consider the context of the assessment.
- Attend to indications of minimization of suicidality. Seek collateral information.
- Collaboratively join with the client to decrease isolation and alienation by:
  - Building the therapeutic alliance
  - Enhancing curiosity about the function of suicidality
  - Enhancing the client's experience and expression of intense emotions

(Fowler, 2013; Nagdimon et al., 2021)

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Risk Factors

(AFSP, n.d.; CDC, n.d.)

- Mental health conditions
- Serious physical health conditions
- Access to lethal means
- Harassment
- Bullying
- Unemployment
- Substance use or abuse
- Divorce or end of relationship
- Financial crisis
- Life transition
- Exposure to another person's suicide
- Previous suicide attempts
- Family history of suicide
- Childhood abuse, neglect, or trauma
- Lack of access to mental health treatment
- Relationship problems
- Loss

*Risk factors can vary by age group, gender identity, culture, sexual orientation, etc.

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Warning Signs

(AFSP, n.d.; CDC, n.d.)

- Talking about being a burden
- Being isolated, withdrawing from activities
- Increased anxiety, anger, or rage
- Talking about having no reason to live
- Talking about feeling trapped or in unbearable pain
- Increased substance use
- Looking for a way to access lethal means
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Extreme mood swings
- Expressing hopelessness
- Sleeping too much or too little
- Feelings of humiliation or shame
- Talking or posting about wanting to die
- Making plans for suicide
- Relief or sudden improvement

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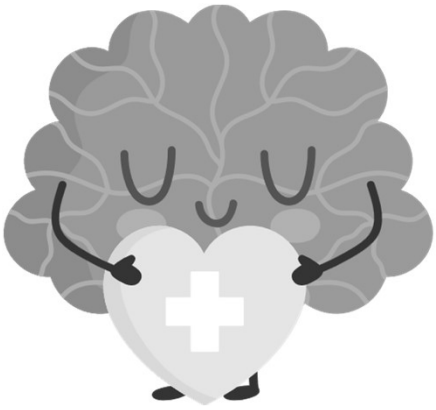
Protective Factors



(AFSP, n.d.; CDC, n.d.)

- Access to mental health care and being proactive about mental health
- Feeling connected to family and community support
- Involvement in work or school
- Identifies reasons for living (i.e., family, friends, pets, etc.)
- Problem-solving and coping skills
- Limited access to lethal means
- Strong sense of cultural identity
- Cultural and/or religious beliefs that encourage connecting and help-seeking, discourage suicidal behavior, or create a strong sense of purpose or self-esteem

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Risk Assessment

- Risk factors
- Protective factors
- Two-diminsional risk stratification:
  - Severity (low, moderate, high)
  - Temporality (acute or chronic)
- Baseline for SI

(Wortzel et. al, 2014)

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Suicide Intervention Strategies

- Motivational Interviewing during safety planning increases self-efficacy to refrain from suicidal action and improves reliance on self to cope with SI in adolescents. Parents were also more motivated to encourage adolescents to follow the safety plan (Czyz et al., 2019)
- Shift away from safety planning (clinician focus) to coping planning (client focus). This includes three steps: care, collaboration, and connection (Stallman, 2018).
- Safety contracts: there is no causative relationship to preventing self-harm/suicide (Drew, 2001).
- Improve emotional regulation self-efficacy. Gratz et al. (2020) stated that by increasing one's confidence in their ability to regulate their emotions, this may decrease suicide risk.

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Suicide Intervention Strategies

Crisis Response Planning

- A personalized problem-solving tool to help individuals manage a crisis.
- More effective than traditional safety plan (only research was for military and veteran populations)
- Components:
  - Narrative Assessment: "story" of the suicidal crisis
  - Warning Signs: indicators that the plan should be used
  - Self-Management: strategies to reduce stress
  - Reasons for Living: creates a sense of purpose in life
  - Social Support: someone to contact
  - Healthcare Professionals: contact info for professional support
  - Crisis Services Resources

(Rozek & Bryan, 2020)

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Self-Care for Mental Health Counselors

- Participating in therapy
- Finding support groups
- Diversifying caseload
- Seeking out formal supervision or consultation
- Socializing
- Engaging in regular sleep
- Exercise
- Eating routines
- Knowing your own limits

(Holliday-Okumu, 2018)

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Questions

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References

- American Foundation for Suicide Prevention (n.d.). Risk factors, protective factors, and warning signs. https://afsp.org/risk-factors-protective-factors-and-warning-signs
- Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal ideation: The scale for suicidal ideation. Journal of Consulting and Clinical Psychology, 47, 343-352. https://doi.org/10.1037//0022-006x.47.2.343
- Berg, R., Hendricks, B., & Bradley, L. (2009). Counseling suicidal adolescents within family systems: Ethical issues. The Family Journal: Counseling and Therapy for Couples and Families, 17(1). 64-68. https://doi.org/10.1177/1066480708328601
- CDC. (2023, May 9). Disparities in suicide. https://www.cdc.gov/suicide/facts/disparities-in-suicide.html
- Centers for Disease Control and Prevention (CDC) (2022). Multiple Cause of Death by Single Race 2018-2021. CDC WONDER Online Database. https://wonder.cdc.gov
- Centers for Disease Control and Prevention (n.d.). Risk and protective factors. Suicide Prevention. https://www.cdc.gov/suicide/factors/index.html
- Czyz, E. K., King, C. A., & Biermann, B. J. (2019). Motivational interviewing-enhanced safety planning for adolescents at high suicide risk: A pilot randomized controlled trial. Journal of Clinical Child & Adolescent Psychology, 48(2), 250-262. https://doi.org/10.1080/15374416.2018.1496442
- Drew, B. L. (2001). Self-harm behavior and no-suicide contracting in psychiatric inpatient settings. Archives of Psychiatric Nursing, 15(3), 99-106.
- Fowler, J. C. (2013). Core principles in treating suicidal patients. Psychotherapy, 50(3), 268-272. https://doi.org/10.1037/a0032030
- Giddens, J. M., Sheehand, K. H., & Sheehan, D. V. (2014). The Columbia-Suicide Severity Rating Scale (C-SSRS): Has the “gold standard” become a liability? Innovations in Clinical Neuroscience, 11(9-10), 66-80.
- Gipson, P. Y., Agarwala, P., Opperman, K. J., Horwitz, A., & King, C. A. (2015). Columbia-Suicide Severity Rating Scale: Predictive validity with adolescent psychiatric emergency patients. Pediatric Emergency Care, 31(2), 88-94. https://doi.org/10.1097/PEC.0000000000000225
- Gratz, K. L., Spitzen, T. L., & Tull, M. T. (2020). Expanding our understanding of the relationship between nonsuicidal self-injury and suicide attempts: The roles of emotional regulation self-efficacy and the acquired capability for suicide. Journal of Clinical Psychology, 76(9), 1653-1667. https://doi.org/10.1002/jclp.22950
- Gutheil, T. G. (2004). Suicide, suicide litigation, and borderline personality disorder. Journal of Personality Disorders, 18(3), 248-256.

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References

- Holliday-Okumu, A. (2018). To muddy death: How clinicians' perceptions of laws and ethics inform treatment of suicidal clients. ProQuest Dissertations & Theses Global.
- Jobes, D. A. (2017). Clinical assessment and treatment of suicidal risk: A critique of contemporary care and CAMS as a possible remedy. Practice Innovations, 2(4), 207-220. https://doi.org/10.1037/pri0000054
- Joiner, T., Jr., Van Order, K. A., Witte, T. K., & Rudd, M. D. (2009). The interpersonal theory of suicide: Guidance for working with suicidal clients (First ed.). American Psychological Association. https://doi.org/10.1037/11869-000
- Lexis Law Publishing. (2021). Tennessee Code Annotated. https://advance.lexis.com/container?config=014CJAA5ZGVhZjA3NS02MmMzLTRlZWQtOGJjNC00YzQ1MmZlNzc2YWYKAFBvZENhdGFsb2e9zYpNUjTRaIWVfyrur9ud&crid=2ca21762-e1b8-4fc0-8c5a-0a17ca06ed5c
- Nagdimon, J., McGovern, C., & Craw, M. (2021). Addressing concealed suicidality: A flexible and contextual approach to suicide risk assessment in adults. Journal of Contemporary Psychotherapy, 51(3), 241-250. https://doi.org/10.1007/s10879-021-09493-9
- Rozek, D., & Bryan, C. J. (2020). Integrating crisis response planning for suicide prevention into trauma-focused treatments: A military case example. Journal of Clinical Psychology, 75(5), 852-864. https://doi.org/10.1002/jclp.22920
- Stallman, H. M. (2018). Coping planning: A patient-centered and strengths-focused approach to suicide prevention training. Australasian Psychiatry, 26(2), 141-144. https://doi.org/10.1177/1039856217732471
- Substance Abuse and Mental Health Services Administration. (2022). Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report
- Universal Declaration of Human Rights. (1984). G.A. Res. 217A (III). https://www.ohchr.org/sites/default/files/Documents/Publications/Compilation1.1en.pdf
- Wang, D. W. L., & Colucci, E. (2017). Should compulsory admission to hospital be part of suicide prevention strategies? BJPsych Bulletin, 41(3), 169-171. https://doi.org/10.1192/pb.bp116.055699
- Wortzel, H. S., Homaifar, B., Matarazzo, B., & Brenner, L. A. (2014). Therapeutic risk management of the suicidal patient: Stratifying risk in terms of severity and temporality. Journal of Psychiatric Practice, 20(1), 63-67.